City of Seattle COBRA enrollment form

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY #
ADDRESS	CITY	STATE	ZIP CODE
E-MAIL ADDRESS	HOME PHONE	WORK PHONE	BIRTHDATE

DENTIST #

REQUESTED EFFECTIVE DATE

SEX

☐ Male

☐ Female

OFFICE USE ONLY

_W-202_____

GROUP # EFFECTIVE DATE

Dependants to be covered*

LAST NAME	FIRST NAME	M.I.	SEX	RELATIONSHIP	BIRTHDATE

* Dependants include your spouse, domestic partner and/or unmarried children who are 23 years of age and younger. Children over 23 years of age are eligible only while the child is and continues to be both (1) incapable of sustaining employment by reason of developmental disability or physical challenge, and (2) is chiefly dependent upon the subscriber for support and maintenance.

By submitting this form, I authorize my dentist to release any information regarding patient history to Dental Health Services, consulting professionals, or other entities designated or approved by Dental Health Services for the purpose of certifying, purchasing, providing, evaluating, or administering benefits. The authorization remains in effect until revoked by me in writing. I also certify that I am at least 18 years of age.

SIGNATURE DATE

Dental Health Services • 936 N 34th Street, Suite 208 • Seattle, WA 98103 • 877.495.4455